FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032839

Facility Name: GLENWOOD HEALTHCARE & REHAB

Address: 19330 SOUTH COTTAGE GROVE AVE (Number) GLENWOOD (City) 60425 (Zip Code)

County: COOK

Telephone Number: (847) 674-4700 **Fax #** (847) 674-4733

IDPA ID Number: 36-3532094

Date of Initial License for Current Owners: 09/01/87

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: DON FIETS **Telephone Number:** (847) 674-4700 X40

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) BRADLEY ALTER
(Title) SECRETARY

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	92	Skilled (SNF)	92	33,580	1
2		Skilled Pediatric (SNF/PED)			2
3	92	Intermediate (ICF)	92	33,580	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	184	TOTALS	184	67,160	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,527		3,062	4,589	8
9	SNF/PED					9
10	ICF	32,153	1,419	1,531	35,103	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,680	1,419	4,593	39,692	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.10%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/01/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/01/87 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 19 and days of care provided 3,062

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	219,198	11,901	7,020	238,119		238,119		238,119			1
2	Food Purchase		175,793		175,793		175,793	(345)	175,448			2
3	Housekeeping	164,528	42,715		207,243		207,243		207,243			3
4	Laundry	79,500	14,374	148	94,022		94,022		94,022			4
5	Heat and Other Utilities			133,082	133,082		133,082	805	133,887			5
6	Maintenance	49,526	35,087	19,427	104,040		104,040	527	104,567			6
7	Other (specify):*			7,130	7,130		7,130		7,130			7
8	**TOTAL General Services**	512,752	279,870	166,807	959,429		959,429	987	960,416			8
	B. Health Care and Programs											
9	Medical Director			13,400	13,400		13,400		13,400			9
10	Nursing and Medical Records	1,524,437	113,144	108,580	1,746,161		1,746,161	33,143	1,779,304			10
10a	Therapy	29,244	4,576	4,894	38,714		38,714		38,714			10a
11	Activities	125,285	2,405		127,690		127,690		127,690			11
12	Social Services	78,906		1,235	80,141		80,141		80,141			12
13	CNA Training											13
14	Program Transportation			1,546	1,546		1,546		1,546			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,757,872	120,125	129,655	2,007,652		2,007,652	33,143	2,040,795			16
	C. General Administration											
17	Administrative	134,186		61,452	195,638		195,638	(15,585)	180,053			17
18	Directors Fees											18
19	Professional Services			90,126	90,126		90,126	(48,209)	41,917			19
20	Dues, Fees, Subscriptions & Promotions			21,751	21,751		21,751	(9,499)	12,252			20
21	Clerical & General Office Expenses	98,706	17,149	204,773	320,628		320,628	(49,264)	271,364			21
22	Employee Benefits & Payroll Taxes			472,892	472,892		472,892	16,484	489,376			22
23	Inservice Training & Education			150	150		150		150			23
24	Travel and Seminar			2,967	2,967		2,967	11,389	14,356			24
25	Other Admin. Staff Transportation			8,578	8,578		8,578	10,433	19,011			25
26	Insurance-Prop.Liab.Malpractice			194,816	194,816		194,816	17,540	212,356			26
27	Other (specify):* marketing	40,128			40,128		40,128	(40,128)				27
28	**TOTAL General Administration**	273,020	17,149	1,057,505	1,347,674		1,347,674	(106,839)	1,240,835			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,543,644	417,144	1,353,967	4,314,755		4,314,755	(72,709)	4,242,046			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: GLENWOOD HEALTHCARE & REHAB #0032839 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	7,020	
	REPAIRS & MAINTENANCE		0	
			0	7,020
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		148	
			0	148
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		45,904	
	ELECTRICITY		61,871	
	WATER		23,874	
	CABLE TV - LOBBY		1,433	
			0	133,082
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		11,360	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		4,457	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,487	
	FIRE SERVICE		1,123	
			0	
			0	
			0	19,427
7	**OTHER**			
	SCAVENGER		7,130	
	SECURITY SERVICE		0	7,130
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	13,400	13,400

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	101,449	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		2,952	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	459	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,170	
	PHARMACY CONSULTANT	XVIII B 39-2	0	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	2,550	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	108,580
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	757	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	2,920	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	1,217	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	4,894
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	1,235	
			0	1,235
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB #0032839 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		1,546	1,546
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	61,452	61,452
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	8,646	
	ADMINISTRATIVE CONSULTANTS	XIX C	47,748	
	PROFESSIONAL FEES	XIX C	33,732	
			0	90,126
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	7,752	
	EMPLOYEE WANT ADS	XIX F	8,311	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	0	
	LICENSES & PERMITS	XIX F	3,862	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	1,826	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	21,751
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		1,798	
	OUTSIDE CLERICAL SERVICES		180,996	
	PENALTIES / OVERDRAFT CHARGES	VI 18	7,305	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		190	
	TELEPHONE		12,075	
	MESSENGER SERVICE-postage		2,409	
			0	204,773

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	190,046	
	UNEMPLOYMENT COMPENSATION	XIX D	61,355	
	WORKERS COMPENSATION INSURANCI	XIX D	115,341	
	HOSPITALIZATION INSURANCE	XIX D	94,944	
	EMPLOYEE BENEFITS - OTHER	XIX D	1,850	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	9,356	
	CHICAGO HEAD TAX	XIX D	0	472,892
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		150	150
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	2,967	
			0	
			0	2,967
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		8,578	8,578
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		194,816	194,816
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER 1,353,967

GLENWOOD HEALTHCARE & REHAB
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	175,793	PATIENT MEALS	119076
LESS SALES TAX	(345)	ADD EMPLOYEE MEALS	0
NET FOOD	175,448	TOTAL MEALS/YEAR	119076
TOTAL PATIENT CENSUS	39,692	NET FOOD	175448
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	119076
TOTAL PATIENT MEALS	119076	COST PER MEAL	1.47
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB #0032839 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			50,411	50,411		50,411	194,522	244,933			30
31	Amortization of Pre-Op. & Org.							24,533	24,533			31
32	Interest			34,118	34,118		34,118	471,110	505,228			32
33	Real Estate Taxes			347,075	347,075		347,075		347,075			33
34	Rent-Facility & Grounds			579,042	579,042		579,042	(573,251)	5,791			34
35	Rent-Equipment & Vehicles			22,805	22,805		22,805		22,805			35
36	Other (specify):* **storage rental**			129	129		129		129			36
37	**TOTAL Ownership**			1,033,580	1,033,580		1,033,580	116,914	1,150,494			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		98,405	319,838	418,243		418,243		418,243			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			100,740	100,740		100,740		100,740			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		98,405	420,578	518,983		518,983		518,983			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,543,644	515,549	2,808,125	5,867,318		5,867,318	44,205	5,911,523			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	26,497	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(345)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(7,305)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(7,752)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,826)	20		28
29	Other-Attach Schedule marketing	(40,128)	27		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (30,859)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	80,922		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 80,922		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 50,063		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

GLENWOOD HEALTHCARE & REHAB

ID# 0032839

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2	LEGAL FEES	(5,858)	19	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(5,858)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(345)	0	0	0	0	0	0	0	0	0	0	(345)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	805	0	0	0	0	0	0	0	0	805	5
6	Maintenance	0	0	527	0	0	0	0	0	0	0	0	527	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(345)	0	1,332	0	0	0	0	0	0	0	0	987	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	33,143	0	0	0	0	0	0	0	0	33,143	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	33,143	0	0	0	0	0	0	0	0	33,143	16
	C. General Administration													
17	Administrative	0	(61,452)	45,867	0	0	0	0	0	0	0	0	(15,585)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,858)	(47,748)	5,397	0	0	0	0	0	0	0	0	(48,209)	19
20	Fees, Subscriptions & Promotions	(9,578)	0	79	0	0	0	0	0	0	0	0	(9,499)	20
21	Clerical & General Office Expenses	(7,305)	(173,743)	131,784	0	0	0	0	0	0	0	0	(49,264)	21
22	Employee Benefits & Payroll Taxes	0	0	16,484	0	0	0	0	0	0	0	0	16,484	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	11,389	0	0	0	0	0	0	0	0	11,389	24
25	Other Admin. Staff Transportation	0	0	10,433	0	0	0	0	0	0	0	0	10,433	25
26	Insurance-Prop.Liab.Malpractice	0	0	17,540	0	0	0	0	0	0	0	0	17,540	26
27	Other (specify):* **marketing**	(40,128)	0	0	0	0	0	0	0	0	0	0	(40,128)	27
28	**TOTAL General Administration**	(62,869)	(282,943)	238,973	0	0	0	0	0	0	0	0	(106,839)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(63,214)	(282,943)	273,448	0	0	0	0	0	0	0	0	(72,709)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	26,497	164,900	3,125	0	0	0	0	0	0	0	0	194,522	30
31	Amortization of Pre-Op. & Org.	0	24,533	0	0	0	0	0	0	0	0	0	24,533	31
32	Interest	0	471,110	0	0	0	0	0	0	0	0	0	471,110	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(579,042)	5,791	0	0	0	0	0	0	0	0	(573,251)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	26,497	81,501	8,916	0	0	0	0	0	0	0	0	116,914	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(36,717)	(201,442)	282,364	0	0	0	0	0	0	0	0	44,205	45

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
BRADLEY ALTER	22.83	SEE ATTACHED SCHEDULE		CERTIFIED HEALTH	SKOKIE	BKKPG/MGMT
RITA L. GELLER	38.04			MANAGEMENT		
JOSEPH C. CHOW	39.13					
				GLENWOOD	SKOKIE	REAL ESTATE
				TERRACE LLC		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 61,452	CERTIFIED HEALTH MGMT		$	$ (61,452)	1
2	V	21	BOOKKEEPING	180,996				(180,996)	2
3	V	19	ADMIN CONSULTING FEES	47,748				(47,748)	3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	579,042	GLENWOOD TERRACE LLC			(579,042)	7
8	V	21	OFFICE EXPENSE				7,253	7,253	8
9	V	30	DEPRECIATION				164,900	164,900	9
10	V	31	AMORTIZATION				24,533	24,533	10
11	V	32	INTEREST				471,110	471,110	11
12	V								12
13	V								13
14	Total			$ 869,238			$ 667,796	$ * (201,442)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	CERTIFIED HEALTH MANAGEMENT		$	$	15
16	V	5	ELECTRIC/GAS		" " "		805	805	16
17	V	6	MAINTENANCE		" " "		527	527	17
18	V	10	NURSING/MEDICAL RECORDS		" " "		33,143	33,143	18
19	V	17	ADMIN SALARIES		" " "		45,867	45,867	19
20	V	19	PROFESSIONAL FEES		" " "		5,397	5,397	20
21	V	20	FEES, SUBSCRIPTION		" " "		79	79	21
22	V	21	OFFICE EXP		" " "		131,784	131,784	22
23	V	22	EMPLOYEE BENEFITS		" " "		16,484	16,484	23
24	V	24	TRAVEL.SEMINAR		" " "		11,389	11,389	24
25	V	25	TRANSPORTATION		" " "		10,433	10,433	25
26	V	26	INSURANCE		" " "		17,540	17,540	26
27	V	30	DEPRECIATION		" " "		3,125	3,125	27
28	V	32	INTEREST		" " "				28
29	V	34	OFFICE RENT		" " "		5,791	5,791	29
30	V	35	EQUIPMENT RENTAL		" " "				30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 282,364	$ * 282,364	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	BRADLEY ALTER		ADMINISTRATION		SEE ATTACHED SCHEDULE			SALARY	$ 57,752	17-3	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 57,752		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CERTIFIED HEALTH MANAGEMENT
Street Address: 3856 OAKTON SUITE 200
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((847) 674-4700
Fax Number: ((847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PER PATIENT DAY	246,749	8	$ 0	$	39,692	$ 0	1
2	5	ELECTRIC & GAS	" " "	246,749	8	5,007		39,692	805	2
3	6	MAINTENANCE	" " "	246,749	8	3,275		39,692	527	3
4	10	NURSING/MEDICAL RECORDS	" " "	246,749	8	206,038	206,038	39,692	33,143	4
5	17	ADMIN SALARIES	" " "	246,749	8	285,136	285,136	39,692	45,867	5
6	19	PROFESSIONAL FEES	" " "	246,749	8	33,552		39,692	5,397	6
7	20	FEE, SUBSCRIPTIONS	" " "	246,749	8	490		39,692	79	7
8	21	OFFICE EXP.	" " "	246,749	8	819,245	705,623	39,692	131,784	8
9	22	EMPLOYEE BENEFITS	" " "	246,749	8	102,474		39,692	16,484	9
10	24	TRAVEL/SEMINAR	" " "	246,749	8	70,798		39,692	11,389	10
11	25	TRANSPORTATION	" " "	246,749	8	64,859		39,692	10,433	11
12	26	INSURANCE	" " "	246,749	8	109,041		39,692	17,540	12
13	30	DEPRECIATION	" " "	246,749	8	19,425		39,692	3,125	13
14	32	INTEREST	" " "	246,749	8	0		39,692	0	14
15	34	OFFICE RENT	" " "	246,749	8	36,000		39,692	5,791	15
16	35	EQUIPMENT RENTAL	" " "	246,749	8	0		39,692	0	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,755,340	$ 1,196,797		$ 282,364	25

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: GLENWOOD TERRACE LLC
Street Address: 3856 OAKTON SUITE 200
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((847) 674-4700
Fax Number: ((847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT COSTS	1	1	$ 164,990	$	1	$ 164,990	1
2	31	AMORTIZATION		1	1	24,533		1	24,533	2
3	32	INTEREST		1	1	471,110		1	471,110	3
4	21	OFFICE EXP		1	1	7,253		1	7,253	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 667,886	$		$ 667,886	25

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BANK FINANCIAL		X	WORKING CAPITAL	DEMAND					PRIME+	31,449	6
7	INS FINANCING		X								2,669	7
8												8
9	TOTAL Facility Related						$	$			$ 34,118	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 34,118	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	384,003	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	380,219	2
3. Under or (over) accrual (line 2 minus line 1).	$	(3,784)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	387,824	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND** $ 36,965 **For** 2002 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	(36,965)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	347,075	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	402,704	8
2001	430,062	9
2002	430,062	10
2003	376,473	11
2004	380,219	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 102% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GLENWOOD HEALTHCARE & REHAB COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0032839

CONTACT PERSON REGARDING THIS REPORT DON FIETS

TELEPHONE (847) 674-4700 FAX #: (847) 674-4733

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	32-10-201-009-0000	NURSING HOME	$ 380,219.00	$ 380,219.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 380,219.00	$ 380,219.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 98,010 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1999	$ 322,000	1
2					2
3	TOTALS			$ 322,000	3

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	184		1999		$ 5,474,000	$ 140,359	39	$ 140,359	$	$ 982,513	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1988	20,662	656	30	689	33	11,746	9
10	LEASEHOLD IMPROVEMENTS			1989	4,071	129	30	136	7	2,244	10
11	LEASEHOLD IMPROVEMENTS			1990	28,171	894	30	939	45	14,555	11
12	LEASEHOLD IMPROVEMENTS			1991	31,712	1,007	30	1,057	50	15,327	12
13	LEASEHOLD IMPROVEMENTS			1992	10,071	320	30	336	16	4,536	13
14	LEASEHOLD IMPROVEMENTS			1993	4,810	153	30	160	7	2,063	14
15	LEASEHOLD IMPROVEMENTS			1994	17,744	455	39	455	(0)	4,777	15
16	LIGHT FIXTURES, ROOM SIGNS, HAND RAILS			1995	6,343	163	39	163	(0)	1,927	16
17	HEATING/AIR CONDITIONING			1995	12,515	320	39	321	1	3,785	17
18	NURSING STATION			1995	10,384	266	39	266	0	3,048	18
19	SPRINKLER/LANUDRY VENTILATION REPAIR			1995	2,360	61	39	61	(0)	685	19
20	LAMPS, VIDEO CAMERA, PANIC DEVICE, WATER COOLER			1996	3,650	94	39	94	(0)	1,001	20
21	EXIT & OUTDOOR SIGNS			1996	4,237	109	39	109	(0)	1,136	21
22	WINDOWS, DOORS, CEILING TILES/CARPET			1996	25,090	643	39	643	0	6,561	22
23	HVAC WIRING REPAIR			1996	1,540	39	39	39	0	401	23
24	TIME CLOCKS,HEAT & COOL UNITS			1997	7,022	180	39	180	0	1,538	24
25	NURSE STATION			1997	5,615	144	39	144	(0)	1,230	25
26	FLOOR/CEILING TILES, COUNTER & CABINETS			1997	21,659	556	39	555	(1)	4,815	26
27	DOORS, LIGHTS, SIGHNS			1997	14,825	380	39	380	0	3,318	27
28	BURNERS & ELECTRICAL FOR WASHER			1997	1,964	50	39	50	0	427	28
29	SIGNS, PATIO SURFACE			1998	6,994	466	15	466	0	3,495	29
30	WINDOWS & INSTALLATION			1998	18,944	486	39	486	(0)	3,868	30
31	KITCHEN REMODEL			1998	50,500	1,295	39	1,295	(0)	10,308	31
32	ELECTRIC WORK			1998	7,545	193	39	193	0	1,456	32
33	CARPET, WALLPAPER, HANDRAIL, BUMPER GUARD			1998	79,382	2,036	39	2,035	(1)	14,777	33
34	GENERATOR			1999	56,533	1,450	39	1,450	(0)	10,091	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	HEAT AND AIR CONDITIONER	1999	$ 14,673	$ 376	39	$ 376	$ 0	$ 2,460	37
38	VINYL FLOORING AND TILES	1999	5,505	141	39	141	0	911	38
39	ROOF AND TUCKPOINT	1999	59,360	1,522	39	1,522	0	9,704	39
40	AIR CONDITIONER/COMPRESSOR	2000	9,868	1,410	7	1,410	(0)	9,467	40
41	ROOF REPAIR	2000	3,750	136	27.5	136	0	788	41
42	VINYL TILE/COVE BASE	2000	19,277	701	27.5	701	(0)	3,992	42
43	ALARM WORK	2000	3,848	140	27.5	140	(0)	726	43
44	DRAPERIES	2001	1,750	64	27.5	64	(0)	312	44
45	ELECTRICAL WORK	2001	5,550	201	27.5	202	1	934	45
46	TILE	2002	13,079	476	27.5	476	(0)	1,607	46
47	TILE	2003	13,545	493	27.5	493	(0)	1,211	47
48	WALL AC UNITS	2003	1,246	45	27.5	45	0	111	48
49	WALL CASE FOR AC	2003	622	23	27.5	23	(0)	56	49
50	WALL CASE FOR AC	2003	631	23	27.5	23	(0)	57	50
51	WALL CASE FOR AC	2003	607	22	27.5	22	0	54	51
52	SHINGLES	2003	700	25	27.5	25	0	62	52
53	COVE BASE	2003	939	34	27.5	34	0	84	53
54	WALL AC UNITS	2003	1,223	44	27.5	44	0	108	54
55	WALL AC UNITS	2003	2,113	77	27.5	77	(0)	189	55
56	WINDOW TREATMENTS	2003	24,200	4,646	5	4,840	194	12,100	56
57	LANDSCAPING	2003	16,500	1,100	15	1,100		2,567	57
58	ELECTRICAL WORK	2004	2,400	87	27.5	87	0	174	58
59	DOOR REPLACEMENT	2004	537	20	27.5	20	(0)	30	59
60	ROOF REPAIR	2004	6,900	251	27.5	251	(0)	376	60
61	DINING ROOM DOOR CONTROL UNIT	2004	1,317	48	27.5	48	(0)	72	61
62	FRONT DOOR CONTROL UNIT	2004	1,318	48	27.5	48	(0)	72	62
63	COVE BASE	2004	1,087	40	27.5	40	(0)	60	63
64	RESIDENT DOORS REFINISHED/INSTALLED	2004	5,500	200	27.5	200		300	64
65	WALLPAPER REMOVAL/INSTALL	2004	11,251	409	27.5	409	0	614	65
66	KICK PLATES	2004	2,453	89	27.5	89	0	134	66
67	WALL AC UNITS	2004	2,291	83	27.5	83	0	125	67
68	WALLPAPER REMOVAL/INSTALL	2004	10,928	397	27.5	397	0	596	68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,173,311	$ 166,275		$ 166,627	$ 352	$ 1,161,681	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,173,311	$ 166,275		$ 166,627	$ 352	$ 1,161,681	1
2	WALL AC UNITS	2005	10,799	2,160	5	1,080	(1,080)	1,080	2
3	EXHAUST/VENTALATION REPAIRS	2005	24,873	490	27.5	452	(38)	452	3
4	LANDSCAPING RENOVATION	2005	2,800	62	15	93	31	93	4
5	RESIDENT DOOR REFINISHED/INSTALLED	2005	16,539	175	27.5	301	126	301	5
6	SIDEWALK INSTALLATION	2005	4,350	48	15	145	97	145	6
7	SMOKE DETECTOR UPGRADE/INSTALL	2005	3,250	15	27.5	59	44	59	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,235,922	$ 169,225		$ 168,757	$ (468)	$ 1,163,811	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 319,396	$ 19,133	$ 47,318	$ 28,185		$ 183,987	71
72	Current Year Purchases	12,213	2,442	1,221	(1,221)		1,221	72
73	Fully Depreciated Assets	125,423					125,423	73
74			27,636	27,636				74
75	TOTALS	$ 457,032	$ 49,211	$ 76,175	$ 26,964		$ 310,631	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,014,954	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 218,436	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 244,933	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 26,497	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,474,443	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO
16. Rental Amount for movable equipment: $ 22,805 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 161,964	$		$ 161,964	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			5,375			5,375	2
3	Licensed Recreational Therapist	39-3	hrs							3
4	Licensed Physical Therapist	39-3	hrs			152,499			152,499	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				88,842		88,842	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MEDICAL SUPPLIES & Other (specify): LABORATORY	39-2					9,563		9,563	13
14	TOTAL			$		$ 319,838	$ 98,405		$ 418,243	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2005 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 80,466)	784,930		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	69,380		6
7	Other Prepaid Expenses	12,176		7
8	Accounts Receivable (owners or related parties)	(111,854)		8
9	Other(specify): RE TAX ESCROW	364,799		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,119,431	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	761,923		15
16	Equipment, at Historical Cost	492,842		16
17	Accumulated Depreciation (book methods)	(634,807)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 619,958	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,739,389	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 852,885	$	26
27	Officer's Accounts Payable	44,320		27
28	Accounts Payable-Patient Deposits	13,000		28
29	Short-Term Notes Payable	450,576		29
30	Accrued Salaries Payable	26,146		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,887		31
32	Accrued Real Estate Taxes(Sch.IX-B)	387,824		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,787,638	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,787,638	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (48,249)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,739,389	$	48

*(See instructions.)

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 257,370	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 257,370	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(305,619)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (305,619)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (48,249)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,305,436	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,305,436	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	237,960	6
7	Oxygen	12,795	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 250,755	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMM NET OF COSTS	5,508	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,508	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,561,699	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	959,429	31
32	Health Care	2,007,652	32
33	General Administration	1,347,674	33
	B. Capital Expense		
34	Ownership	1,033,580	34
	C. Ancillary Expense		
35	Special Cost Centers	418,243	35
36	Provider Participation Fee	100,740	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,867,318	40
41	**Income before Income Taxes (line 30 minus line 40)****	(305,619)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (305,619)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,064	2,080	$ 61,955	$ 29.79	1
2	Assistant Director of Nursing	1,756	1,764	52,241	29.62	2
3	Registered Nurses	4,164	4,256	123,231	28.95	3
4	Licensed Practical Nurses	23,061	24,194	543,058	22.45	4
5	CNAs & Orderlies	72,877	75,945	660,289	8.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,721	2,123	29,244	13.77	8
9	Activity Director	355	355	4,253	11.98	9
10	Activity Assistants	10,976	11,788	121,032	10.27	10
11	Social Service Workers	6,221	6,269	78,906	12.59	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	39,086	18.79	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,717	7,597	61,017	8.03	15
16	Dishwashers	12,273	13,725	119,095	8.68	16
17	Maintenance Workers	3,489	3,625	49,526	13.66	17
18	Housekeepers	17,329	18,552	164,528	8.87	18
19	Laundry	8,299	9,074	79,500	8.76	19
20	Administrator	948	1,028	31,690	30.83	20
21	Assistant Administrator	4,040	4,160	102,496	24.64	21
22	Other Administrative					22
23	Office Manager	4,040	4,160	67,647	16.26	23
24	Clerical	2,392	2,490	31,059	12.47	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,058	3,080	38,753	12.58	31
32	Other Health C: care plan coord	2,031	2,080	44,910	21.59	32
33	Other(specify) marketing	2,000	2,080	40,128	19.29	33
34	TOTAL (lines 1 - 33)	191,811	202,505	$ 2,543,644 *	$ 12.56	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	200	$ 7,020	1-3	35
36	Medical Director	1200/month	13,400	9-3	36
37	Medical Records Consultant	35	1,170	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		0	10-3	39
40	Physical Therapy Consultant	16	757	10a-3	40
41	Occupational Therapy Consultant	73	2,920	10a-3	41
42	Respiratory Therapy Consultant	27	1,217	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant	40	1,235	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	391	$ 27,719		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	594	$ 29,585	10-3	50
51	Licensed Practical Nurses	1,924	71,560	10-3	51
52	Certified Nurse Assistants/Aides	8	304	10-3	52
53	TOTAL (lines 50 - 52)	2,526	$ 101,449		53

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
AHARON ADLER	ADMIN	0	$ 27,199
CELESTE PHILLIPS	ASST ADMIN	0	63,229
LISA SMITH	ASST ADMIN	0	39,267
DEBORAH MUSSEN	ADMIN		4,491
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 134,186

B. Administrative - Other

Description	Amount
CERTIFIED HEALTH MGMT	$ 61,452
TOTAL (agree to Schedule V, line 17, col. 3)	$ 61,452
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		90,126
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 90,126

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 115,341
Unemployment Compensation Insurance		61,355
FICA Taxes		190,046
Employee Health Insurance		94,944
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		1,850
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		9,356
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
MGMT CO ALLOCATION		16,484
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 489,376

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	8,311
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	9,578
TRUST/FRANCHISE/CONTRIB/ETC	0
LICENSES & PERMITS	3,862
DUES & SUBSCRIPTIONS	0
MGMT CO ALLOCATION	79
TRUST/FRANCHISE/CONTRIB/ETC	0
Less: Public Relations Expense	(0)
Non-allowable advertising	(7,752)
Yellow page advertising	(1,826)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,252

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	2,967
Seminar Expense	
	0
MGMT CO ALLOCATION	11,389
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,356

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINT/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **100,740**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees